Introduction and Aims

Chronic Obstructive Pulmonary Disease (COPD) is a chronic condition and is the only major cause of death in Scotland which is rising and is strongly correlated with deprivation. Evidence suggests that COPD patients benefit from an integrated approach which is tailored to their individual needs. Patients need to acquire an active role in the health care process to improve outcomes and reduce the burden of care on health organisations. A community multi disciplinary approach to the treatment and rehabilitation of COPD patients has been identified as good clinical practice. Shared decision making between clinicians and patients about the goals of rehabilitation can have a positive impact on the patient’s health, well being and functional gains and it is associated with improved goal attainment. Collaborative goal setting increases adherence, motivation and improves self management. Current evidence also suggests that there is no defined approach and that there are inconsistencies in the current approaches to collaborative goal setting. Recent evidence suggests that clinicians are setting vague non collaborative goals and that goal setting is frequently driven by the health professional and rarely involves the patient.

Method

The PaVar process (see diagram) was developed for use within a multidisciplinary Community Respiratory Team goal setting process. It’s aim is to move patients from being a passive recipient of care to becoming an involved partner and to undertake collaborative goal setting thereby promoting effective self management of their COPD.

The clinician facilitates the patient to appraise their current situation and identify their current problems. A personalised goal action plan is formulated with the patient, written in their own words and with their own identified outcomes. Patients scored their own goal at the end of intervention with 100% indicating complete success.

A culture of goal setting was embedded within the service through recruitment, induction, supervision and peer support goal setting meetings and targeted training. PDSA cycles focussed on small tests of change for the recruitment, induction, supervision and peer support goal setting. A culture of goal setting was embedded within the service through creating a goal setting documentation and secondly on the targeted training of staff by implementing patient feedback.

COPD Assessment Test (CAT) and EQ5D5 Quality of life measures were used pre and post intervention to demonstrate impact of disease and quality of life. Patient feedback was gained from semi structured telephone interviews.

Results

234 patients undertook collaborative goal setting of which patient centred goal setting was completed with 82% of patients and the average goal attainment was 82%.

CAT scores indicated an average change of 5, which is both clinically and statistically significant.

EQ5D5 showed an average improvement of 10% which is statistically significant.

Correlation was found between CAT scores and Goal Attainment, in that higher gains in impact of disease were made when people achieved their goal. See Figure 1.

Qualitative data indicated that patients were confident in their self management, valued a community based approach and felt achievement when able to achieve their goals. Staff feedback indicated increased ownership and a shift in the balance of condition management towards the patient.

Conclusion

Proving a person centred community respiratory team that works with the patient to produce their own goals and then work towards these goals collaboratively can reduce hospital admissions, improve the impact of the disease and improve the quality of life. Goal setting is an avenue that could benefit all long term condition management.

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